cosmetic surgery AFFILIATES
educated • experienced • sincere

CONSENT FOR ANESTHESIA SERVICES

I, _____, acknowledge that my doctor has explained to me that I will have an operation, diagnostic or treatment procedure. My doctor has explained the risks of the procedure, advised me of alternative treatment and told me about the expected outcome and what could happen if my condition remains untreated. I also understood that anesthesia services are needed so that my doctor can perform the operation or procedure.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia and that additional or specific have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used to determine by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique that involves the use of local anesthetics, with or without sedation. May not succeed completely and therefore another technique may have to be used including general anesthesia.

☐ General Anesthesia	Expected Result	Total unconscious state, possible placement of a tube into the windpipe
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes
	Risks	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia.
☐ Spinal or Epidural Analgesia/Anesthesia	Expected Result	Temporary decrease or loss of feeling and/or movement to lower part of the body.
☐ with sedation	Technique	Drug injected through needle/catheter placed directly into the spinal canal or immediately outside spinal canal.
☐ without sedation	Risks	Headache, backache, buzzing in the ear, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels. "Total spinal."
☐ Major/Minor Nerve Block	Expected Result	Temporary loss of feeling and/or movement of a specific limb or area.
☐ with sedation	Technique	Drug injected near nerves providing loss of sensation to the area of the operation.
☐ without sedation	Risks	Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels.
☐ Intravenous Regional Anesthesia	Expected Result	Temporary loss of feeling and/or movement of a specific limb or area.
☐ with sedation	Technique	Drug injected into the veins of arm or leg while using a tourniquet
☐ without sedation	Risks	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels.
☐ Monitored Anesthesia Care (with sedation)	Expected Result	Reduced anxiety and pains, partial or total amnesia.
	Technique	Drug injected into bloodstream. Breathed into the lungs, or by other routes producing a semi-conscious state.
	Risks	An unconscious state, depressed breathing, injury to blood vessels.
☐ Monitored Anesthesia Care (without sedation)	Expected Result	Measurement of vital signs, availability of anesthesia provider for further intervention.
	Technique	None.
	Risks	Increased awareness, anxiety and/or discomfort.

I hereby consent to the anesthesia service checked above and authorize that it be administered by _____ , who is credentialed to provide anesthesia services at this health facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them. I expressly desire the following considerations be observed or write "none."

_____

_____

I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and to consider my decision.

Patient Signature: _____ Date and Time: _____

Substitute's Signature: _____ Date: _____ Witness: _____

YOU WILL SIGN THIS DOCUMENT ELECTRONICALLY WHEN CHECKING IN TO OUR OFFICE ON THE DAY OF YOUR SURGERY. THERE IS NO NEED TO PRINT THIS DOCUMENT.